



Texas Department of Insurance

Division of Workers' Compensation

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

MYLYSSA M MCDONALD
2760 MONTGOMERY RD #204
HUNTSVILLE TX 77340

DWC Claim #:

Injured Employee:

Date of Injury:

Employer Name:

Insurance Carrier #:

Respondent Name:

STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box

Box Number 45

MFDR Tracking Number:

M4-12-2405-01

MDFR Received Date

MARCH 19, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "My meds are to be paid by Worker's Compensation. Prescriptions were going to expire (Written January 3, 2012). Adjuster would not ok my medications to be filled, so the Pharmist ran the prescriptions on my Medicare. Medicare will have to be reimbursed. These medications were for work related injuries."

Amount in Dispute: \$2.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: On March 23, 2012 a copy of this request for medical fee dispute resolution was forwarded to the State Office of Risk Management. A response to the request was not submitted by the respondent.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April twelfth and April fifteenth of 2010	CPT Codes 62290 72295, 62290-51, 72295-26 and 72295-51	\$2830	0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for injured employees to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.270 sets out the procedures for injured employees to submit workers' compensation out-of-pocket expenses to the insurance carrier for reimbursement.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - Explanation of benefits were not submitted by either party.

Issues

1. Did the requestor submit documentation to support the disputed out-of-pocket expenses were submitted timely in accordance with 28 Texas Administrative Code §133.307(c)(3)(D)?
2. Is the requestor entitled to reimbursement?

Findings

1. On March 28, 2012 the Medical Fee Dispute Resolution manager made copies of the original documents submitted by the injured employee and returned the original documents to the injured employee so that a request for reimbursement for out-of-pockets expenses could be made to the carrier. On October 8, 2012 the State Office of Risk Management was contacted in reference to the injured employee requesting reimbursement for out-of-pocket expenses; at this time it was discovered that the injured worker had not submitted a request for reimbursement

Pursuant to 28 Texas Administrative Code 133.307(c)(3)(D) an employee who has paid for health care may request medical fee dispute resolution of a refund or reimbursement request that has been denied. The employee's dispute request shall be sent to the MDR Section by mail service, personal delivery or facsimile and shall include: a copy of the carrier's or health care provider's denial of reimbursement or refund relevant to the dispute, or, if no denial was received, convincing evidence of the employee's attempt to obtain reimbursement or refund from the carrier or health care provider. The documentation submitted by the injured employee does not contain any convincing evidence that the employee attempted to obtain reimbursement from the carrier.

2. Therefore, the requestor did not meet the requirements of the Texas Administrative Code and reimbursement is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is not due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

November 8, 2012
Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.